QUESTIONNAIRE FOR CODE 8
For humanitarian work abroad or research and teaching abroad

PLEASE PRINT

Name: [FIRST NAME] (MIDDLE NAME) (LAST NAME)

Your CMPA Member number:

1. Will you be doing humanitarian work, teaching or research abroad? Check all the options that apply.
   - Humanitarian work
   - Teaching
   - Research

   NOTE: If teaching or doing research abroad, please provide a copy of the invitation from your host medical facility, institution (university) or humanitarian organization. If possible, provide a copy of the program confirming your participation.

2. How will you perform the work abroad? Check one.
   - I will be on site
   - I will be providing care through telehealth

3. Name of the organization sponsoring your humanitarian work:

4. Name the city, country and hospital or institution where you will be working:
   City: __________________________ Country: __________________________
   Hospital, institution or university: ______________________________________

5. What is the duration of your work abroad?
   Start date: __________________________ End date: __________________________
   (MM/DD/YYYY) (MM/DD/YYYY)

6. Describe the nature of the clinical or teaching activities you will be doing abroad.
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

YOUR CMPA MEMBERSHIP AND MUTUALITY
The CMPA provides liability protection for its members who, in turn, are expected to practise in a manner that aligns with the ethics and expectations of the profession and the values of the Association (the mutual) as described in its Bylaw.
7. Give a brief description of the patients you will be treating. Are they underprivileged or underserviced?

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________________________________________________________________________

________________________________________________________________________

THIS SECTION IS TO BE FILLED OUT BY TRAINEES AND CLINICAL FELLOWS ONLY

8. Explain how your humanitarian work abroad relates to your training or fellowship program.

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________________________________________________________________________

9. Name of supervising physician or teacher accompanying you.

________________________________________________________________________

Signature: Date: (MM/DD/YYYY)

Please return the completed form to the CMPA by fax, mail or member portal (requires member number and password).